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# POLICY AND ADMINISTRATIVE IMPLICATIONS OF THE OREGON MEDICAID PRIORITY-SETTING PROJECT

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**R**ECENT LEGISLATION in the State of Oregon has raised issues of major significance for state and national health policy. The paper by Behrman and Larson discusses some of the policy and administrative issues raised by the Oregon Medicaid Priority Setting Project. The authors give special attention to the impact of the Oregon Proposal on access to health care for children; and I think we should acknowledge our debt to them for so forcefully highlighting the needs and vulnerability of poor children.

The picture the paper paints of child poverty in the United States, changing family structure, inadequate and decreasing health insurance for children and pregnant women, and inadequate federal and state programs is distressing. Adequate health care services alone, unfortunately, will not solve the problems facing poor children. However, surely children - who have so many other disadvantages - should at least be assured of basic medical care? Behrman, Larson and I share a simple premise: on moral grounds, all children are entitled to adequate health care. Presumably this is either a view not shared by, or not a compelling priority for, the political majority in this country, given the absence of adequate mechanisms to ensure that care is provided.

I would like to discuss briefly four aspects of Behrman and Larson's view that the Oregon Proposal has a disproportionate impact on children. Then I will consider Oregon's plan overall and the issue of assessing benefits and costs for state policy-making. My purpose is to raise some questions which I would like to invite readers to consider.

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## WHAT DOES "DISPROPORTIONATE IMPACT" MEAN?

Behrman and Larson point out that children represent a significant percentage of the poor whose care is targeted by Oregon's priority setting and who would bear the brunt of any reductions in service. They state: "Oregon's Proposal exacerbates the problem by specifically excluding all health services to the elderly from the priority setting." Let us assume, for a moment, however, that the Oregon Proposal did *not* exclude the elderly, blind, disabled, etc. from priority setting. Would this remove for Dr. Behrman the objection to the Oregon Proposal on the grounds of "disproportionate impact"?

I suspect not. Behrman and Larson object to the fact that "the mechanism established by the Oregon Proposal greases the wheel for cuts within healthcare." They would prefer a different approach in which nonhealth care services would be considered as well as health care for budget cuts. Let us assume, for the purposes of analysis, that the Oregon Proposal were modified so that (i) the elderly, blind, disabled, etc. were not excluded from priority-setting; and that (ii) the greased wheel mechanism for expenditure cuts was replaced by a defined benefit package that was subject to revision every one or two years. Would this eliminate the concern about "disproportionate impact on children"? Or are other specific modifications required?

It was not entirely clear from the paper at what point the objections to disproportionate impact would be withdrawn - how and when the impact would be "proportionate". The benefit of clarifying this would be to see whether the Oregon Proposal could be effectively modified. Alternatively, one has to ask whether it is simply that children represent a significant percentage of the poor - and that anything one would propose for a Medicaid program has a "disproportionate impact"? Since Medicaid is intended as a program for the poor, to object to changes because they have a disproportionate impact on the poor would be tautological.

## COULD THE RESULTS OF PLANNED CHANGES IN OREGON CONCEIVABLY REPRESENT AN IMPROVEMENT OVER THE PRIOR SITUATION?

The State of Oregon has taken steps to revise Medicaid eligibility which has been extended from 58% to 100% of the federal poverty level. If the Oregon legislature is not willing to provide full

funding for all those potentially eligible, would Dr. Behrman and the rest of us prefer a pre-1987 situation where approximately 54,000 eligible children have a full package of medical benefits - including liver transplants? Or would we prefer to choose to have, say, an additional 46,000 children be assured of the 82% of all benefits categorized as priority-10 benefits, as well as the currently eligible 54,000 children - and forego liver transplant coverage and other "lower-priority" benefits for all these children? From this standpoint one might characterize the impact on the new 46,000 children served as advantageous, not negative as Behrman and Larson's paper implies.

I do not wish to pretend that these types of choices are appealing or desirable. I think they make most of us personally, morally uncomfortable. At this point in time, it is not clear what the future funding level of the Oregon Medicaid program will be or what the particular trade-offs will look like. Unless one tries to wish the problem away, however, this kind of issue is presumably one of the considerations Oregon State officials and legislators have to consider: the adoption of a step which, though far from reaching an ideal standard, might represent a distinct improvement over the prior situation.

### THE ECONOMIC JUSTIFICATION FOR MEDICAL CARE

One of the arguments presented in the paper for strengthening medical care programs for children is the currently fashionable one, that "our future productivity and competitiveness as a nation . . . primarily depends upon the healthy development of children." This may be true. However, I would like to propose that we consider abandoning this apparently appealing argument. From an ethical standpoint it risks reducing a human being's worth to a function of their economic productive value to society. The use of this criterion in the United States would soon lead us presumably to minimize or eliminate most services, for example, for the mentally retarded, retired elderly people, and many other groups.

### SPECIAL INTEREST GROUP ADVOCACY

This leads me to a final concern with the paper's advocacy of health care for children. In light of Dr. Behrman's professional training and his current responsibilities as Director of the Center for the Future of Children this is entirely understandable and proper. Important as child health care is, however, I think there is

a more fundamental question to consider. If one is not careful, this type of child advocacy may foster and encourage "special interest" advocacy - which could be (and is) pursued for a whole range of special interest groups. The danger of this approach in a context like the Cleveland conference is that it may prevent our addressing the more fundamental question: consideration and advocacy of the need to provide basic medical services for all human beings. Yes, children are important - but so are mothers and fathers of teenagers, the elderly, those with chronic disabilities, and many other groups. Special interest groups are a powerful force in the United States. However, is it perhaps incumbent on the kinds of leaders who gathered for the Cleveland conference to forego arguments based upon special interest groups - and to address a more fundamental concern?

One of the fifteen principles adopted in fact by the so-called 1988 Citizens Health Care Parliament in Oregon was that: "Every person is entitled to receive adequate health care." To date, the United States has the distinction, I believe, of being the only industrialized country in the West which does not make provision for basic medical services for all its citizens. If we address this issue - and if this goal were to be achieved - the country would have made a beginning in fact on meeting a priority interest of child advocates and many other special interests.

### ASSESSING OREGON'S PLAN OVERALL

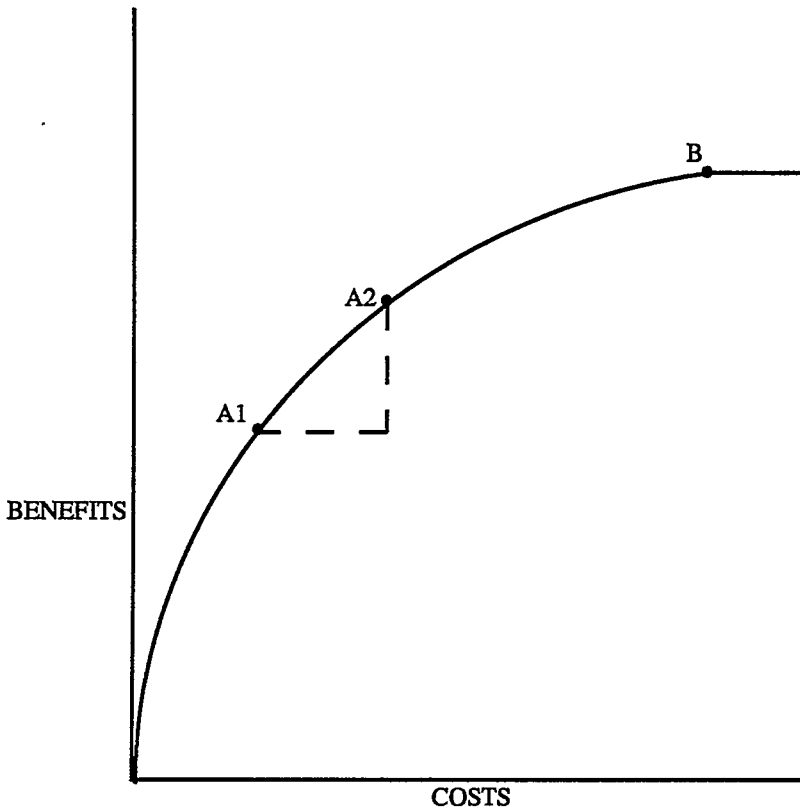
On the basis of the materials I have seen, the State of Oregon, overall, has apparently taken a series of initiatives, many of which appear to be positive. The Principles for Health Care Allocation state: "Every person is entitled to receive adequate health care." The legislature has established a Health Services Commission which is charged to devise an actual benefits package. Senate Bill 27 increased Medicaid eligibility from 58% to 100% of the federal poverty level. Senate Bill 534 creates a seed fund for a state insurance pool for the medically uninsured with pre-existing conditions. Senate Bill 935 goes on to provide that by 1994 all employers must either provide health insurance for employees or make monthly contributions. Perhaps the prioritization process, which is the element which seems to have attracted the most media attention, may prove in the end to be the least important part of what is going on in Oregon. Maybe it is premature; or, as Behrman and Larson suggest at the end of their paper, maybe alternative proposals need to be debated.

In the end, all health plans have some form of prioritization process, even if it is not as evident as the one Oregon is considering. If Oregon needs to define a basic medical care package for the indigent, perhaps alternative methods should be considered. For example, why not just peg the Medicaid program package to that established for another group of people for whom the state has already approved benefits - state employees? This would address the Medicaid benefit issue in Oregon. It would not, of course, address the larger policy questions that we all face at the state and national levels in dealing with the balancing of costs and benefits.

### ASSESSING BENEFITS AND COSTS FOR STATE POLICY MAKING

The debate in which we are involved relates in part to this chart to which the economist Victor Fuchs and others directed our attention in the mid 1970's (see Figure 1 below: Model of Relationship Between Health Costs and Benefits).

Figure 1: Model of Relationship Between Health Costs and Benefits



We are now all familiar with the idea that health policy should be concerned with the relationship between benefits and costs (for example, the incremental benefits gained as incremental expenditures move from point A-1 to point A-2 in Figure 1) and the discussion about “flat of the curve medicine” (point B in Figure 1).

Unfortunately, although economists have presented this conceptual model, we have not yet found a way of satisfactorily operationalizing it for purposes of state and national health policy. One difficulty with applying the model is that the majority of medical care interventions, according to academic physicians, are not yet scientifically proven. Most clinical interventions currently being performed by physicians have not been subjected to careful controlled trials, that stand up to scientific examination. The determination of meaningful cost data is a further problem area. We know very little about the true costs of an efficient producer of medical care; economic costs are needed rather than merely accounting

costs; and the determination of the relevant costs to be used in any application is complex.

The computation of benefits is even more problematic. This is an extraordinarily difficult territory for which it may take 15-20 years to develop satisfactory methodological tools. Beyond measuring benefits, there is the problem of deciding whose assessment of benefits is relevant (e.g., the patient, the physician, the payor, etc.). Once one has solved this type of benefit-cost analysis for several separate procedures, there is the additional problem of aggregation: how one adds up the result of this analysis in Oregon, say, in terms of 1,600 procedures; and how one arrives at an agreed upon set of views for the state (or the legislature).

Oregon has entered into tackling a complex problem which, as a purely intellectual issue, is extraordinarily fascinating. It is going to take many years, I believe, for us to begin to address it effectively. Some critics have argued that there is no scientific basis for what Oregon is doing; however, I think this actually may miss the point. It is true that medicine does not presently have the scientific data to adequately assess the majority of clinical interventions. However, even were it available, medical scientific data would not conclude the analysis Oregon is engaged in. The valuation of benefits and the problems of aggregation are not subject to medical scientific solution. The problem of prioritization which Oregon is addressing is not, in the end, a scientific puzzle.

I have discussed so far the difficulty of developing the data base, methodologies, and processes for tackling in an intellectually rigorous manner the assessment of benefits and costs. This is a problem for academic health policy research. Oregon's legislature, however, faces the problem of developing a "practitioner's" solution.

What Oregon seems to be trying to do at the moment is to deal with the fact that legislators each year are engaging in this kind of process implicitly. They may not realize it; they may choose to ignore it; but whether we like it or not, any set of packages that one defines implicitly involves some judgements about the assessment of benefits and costs. An issue faced by Oregon is that many people outside Oregon focus on the prioritization process and the type of cost/benefit curve illustrated in Figure 1. We may ignore (and Oregon may not be recognized for) all the good things that Oregon has done, as outlined earlier. Perhaps the Oregonians should cut and run. Let them tie a basic benefits package for Medicaid recipients to the benefit plan for state employees, as I proposed earlier. Then they could view the prioritization process as a long term academic



study - a study of potentially critical significance but one that could be pursued perhaps with less heat and emotion if it were not being applied only to the poor, but were to be applied more appropriately to broader segments of the population - or to all of us.